House of Representatives

General Assembly

File No. 842

January Session, 2007

Substitute House Bill No. 7322

House of Representatives, May 16, 2007

The Committee on Appropriations reported through REP. MERRILL of the 54th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAID MANAGED CARE REFORM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-296 of the general statutes is amended by adding subsection (e) as follows (*Effective from passage*):

(NEW) (e) All contracts between the department and a managed care organization to provide services under the HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, or the Medicaid program, and all documents maintained by a managed care organization related to the performance of its contracts with the department, including, but not limited to, contracts and agreements with providers and subcontractors, documents concerning rates paid to providers and subcontractors, and documents concerning operational standards, shall be deemed public records or files as defined in section 1-200 and shall be subject to disclosure in accordance with chapter 14.

Sec. 2. Section 1-218 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each contract in excess of two million five hundred thousand dollars between a public agency and a person for the performance of a governmental function shall (1) provide that the public agency is entitled to receive a copy of records and files related to the performance of the governmental function, and (2) indicate that such records and files are subject to the Freedom of Information Act and may be disclosed by the public agency pursuant to the Freedom of Information Act. Any contract between the Department of Social Services and a managed care organization to provide services under the HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, or the Medicaid program, irrespective of whether such contract is in excess of two million five hundred thousand dollars, shall be subject to the provisions of this section. No request to inspect or copy such records or files shall be valid unless the request is made to the public agency in accordance with the Freedom of Information Act. Any complaint by a person who is denied the right to inspect or copy such records or files shall be brought to the Freedom of Information Commission in accordance with the provisions of sections 1-205 and 1-206.

Sec. 3. Subdivision (11) of section 1-200 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(11) "Governmental function" means the administration or management of a program of a public agency, which program has been authorized by law to be administered or managed by a person, where (A) the person receives funding from the public agency for administering or managing the program, (B) the public agency is involved in or regulates to a significant extent such person's administration or management of the program, whether or not such involvement or regulation is direct, pervasive, continuous or day-to-day, and (C) the person participates in the formulation of governmental policies or decisions in connection with the administration or management of the program and such policies or decisions bind the public agency. "Governmental function" includes the provision of services by a managed care organization under the

HUSKY Plan, Part A, the HUSKY Plan, Part B, or the Medicaid program. "Governmental function" **[**shall**]** does not include the mere provision of goods or services to a public agency without the delegated responsibility to administer or manage a program of a public agency.

Sec. 4. (NEW) (*Effective July 1, 2007*) All contracts between the Department of Social Services and a managed care organization to provide services under the HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, or the Medicaid program, and all documents maintained by a managed care organization related to the performance of its contracts with the department, including, but not limited to, contracts and agreements with providers and subcontractors, documents concerning rates paid to providers and subcontractors, and documents concerning operational standards shall be subject to review and inspection by the Attorney General. In conducting such review or inspection, the Attorney General shall ensure that the provisions of any contract between the department and a managed care organization shall inure to the benefit of the beneficiaries of health care services under the contract. The Attorney General, in the course of performing the duties prescribed in this section, may contemporaneously advise the Commissioner of Social Services, the Governor and the chairpersons of the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies of any concerns that he or she may have concerning a contract between the department and a managed care organization.

Sec. 5. Subsection (d) of section 17b-28 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(d) The Commissioner of Social Services shall provide monthly reports on the plans and implementation of the Medicaid managed care system to the council. Not later than January 1, 2008, the Commissioner of Social Services shall include with such reports the following information for contracts between the department and a

managed care organization: The total dollar value of the contract, along with an accounting of the sums within each contract that are allocated for and then actually expended on preventive care, primary care, specialty care, dental care, care and case management services, outreach and advertising activities, administrative costs, profit margin, subcontractors and any other nonmedical expenses. Not later than January 1, 2008, and annually thereafter, the commissioner shall provide the following information with respect to each managed care organization under contract with the department: (1) Any pharmaceutical rebates provided by a pharmaceutical manufacturer to a managed care organization, (2) the salaries and fringe benefits for the ten highest paid positions of those persons employed by the managed care organization who are responsible for the administration of HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, (3) the total dollar value of any withheld pools representing sums that will be withheld from participating providers if the cost of services rendered by such providers is higher than expected, and (4) any other rebate provided by a manufacturer, vendor or distributor of health care products and equipment to a managed care organization or a subsidiary of such managed care organization.

Sec. 6. (NEW) (*Effective July 1, 2007*) The Department of Social Services shall, on an annual basis, conduct a secret shopper survey with respect to any managed care organization under contract to provide health care services to the department. Such survey shall gauge the effectiveness of the managed care organization's application and enrollment processes and assess the availability of health care provider services for both new and existing program beneficiaries. The department shall utilize a consistent methodology when conducting such survey so as to permit a fair comparison of the results of such survey on an annual basis. Not later than January 1, 2008, and annually thereafter, the Commissioner of Social Services shall report, in accordance with section 11-4a of the general statutes, on the results of such surveys to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

Sec. 7. Section 38a-1041 of the general statutes is amended by adding subsection (f) as follows (*Effective July 1, 2007*):

(NEW) (f) The Office of the Healthcare Advocate shall provide informational assistance to recipients of HUSKY Plan, Part A or Part B benefits. Informational assistance provided by the Office of the Healthcare Advocate shall include, but not be limited to, information on: (1) Selection of the HUSKY Plan option that best meets the needs of the recipient; (2) the enrollment process; (3) primary care provider selection; (4) assistance in negotiating the managed care and Medicaid systems to access health care services; (5) assistance with billing issues; and (6) collaboration with state agency personnel to resolve eligibility, enrollment and access issues.

Sec. 8. (NEW) (*Effective July 1, 2007*) (a) Notwithstanding any provision of the general statutes, not later than January 1, 2008, the Department of Social Services shall begin implementing on not less than a regional basis, a system of primary care case management. Upon the implementation of a primary care case management system, HUSKY Plan, Part A and Part B beneficiaries shall be provided a choice of receiving medical assistance benefits through a primary care case management system or a managed care system. For purposes of this section, "primary care case management" means a system of care in which the health care services for program beneficiaries are coordinated by a primary care provider chosen by or assigned to the beneficiary. "Primary care case management" does not include capitation payment system for medical services provided.

(b) Primary care providers participating in the primary care case management system shall be reimbursed by the state for medical services provided and for health care coordination services provided on behalf of program beneficiaries. Primary care providers shall provide beneficiaries with primary care medical services and arrange for specialty care as needed. The network of primary care providers utilized by the department shall include, but not be limited to, health care professionals employed at community health centers and school-

based health clinics.

(c) The Department of Social Services shall contract with an administrative services organization to coordinate the availability of services under the primary care case management system. In addition, the department may directly contract with any medical provider or group of medical providers in order to facilitate implementation of the primary care case management system. The department when selecting an entity to administer the primary care case management system may not select any managed care organization, subsidiary of, affiliate of or any related company within the control of the managed care organization currently under contract with the department for the provision of managed care.

(d) The Commissioner of Social Services shall develop a program to involve the public in the design and implementation of the primary care case management system and to ensure ongoing public involvement. Such program shall include the opportunity to submit written comments and broad distribution of information and opportunities to the public and to consumers, consumer advocacy groups, medical providers and other organizations involved in health care. Information available to the public shall include one or more preliminary documents identifying the options under consideration by the department for implementation of the primary care case management system. All informational materials shall be available to persons with disabilities and to those who do not speak English. The primary care case management system developed by the department in accordance with the provisions of this section shall include training and educational activities for (1) providers who participate in the program, (2) outreach personnel utilized to promote the program, and (3) beneficiaries who opt to enroll in the program.

(e) The primary care case management system shall be offered to HUSKY Plan, Part A and Part B beneficiaries on a voluntary basis. Any program beneficiary who elects to enroll in the primary care case management system shall be afforded the option of seeking a change

of primary care provider which shall be decided on a case-by-case basis.

(f) The department shall ensure that a beneficiary that elects to participate in the primary case management system has access to dental services and behavioral health services as part of the system.

(g) The department shall provide monthly reports on the progress in planning and developing the primary care case management system to the council established pursuant to section 17b-28 of the general statutes. In addition, not later than six months after the date of implementation of the primary care case management system and annually thereafter, the department shall conduct a comprehensive review of the system that includes system costs, beneficiary satisfaction surveys, provider satisfaction surveys, access and utilization reports, administrative efficiency reports and recommendations for improvement of the system, and after completing such review, the department shall submit a written report on the results to said council.

(h) The Commissioner of Social Services may seek a waiver from federal law, if necessary, in order to implement the primary care case management system in accordance with the provisions of this section.

(i) The commissioner, pursuant to section 17b-10 of the general statutes, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policy shall be valid until the time final regulations are adopted.

Sec. 9. Subsection (i) of section 17b-292 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(i) The single point of entry servicer shall send an application and

supporting documents to the commissioner for determination of eligibility of a child who resides in a household with a family income of one hundred eighty-five per cent or less of the federal poverty level. The servicer shall enroll eligible beneficiaries in the applicant's choice of managed care plan or in the primary care case management system. Upon enrollment in a managed care plan, an eligible HUSKY Plan, Part A or Part B beneficiary shall remain enrolled in such managed care plan for twelve months from the date of such enrollment unless (1) an eligible beneficiary demonstrates good cause to the satisfaction of the commissioner of the need to enroll in a different managed care plan, or (2) the beneficiary no longer meets program eligibility requirements.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	17b-296
Sec. 2	*from passage*	1-218
Sec. 3	*from passage*	1-200(11)
Sec. 4	*July 1, 2007*	New section
Sec. 5	*July 1, 2007*	17b-28(d)
Sec. 6	*July 1, 2007*	New section
Sec. 7	*July 1, 2007*	38a-1041
Sec. 8	*July 1, 2007*	New section
Sec. 9	*July 1, 2007*	17b-292(i)

APP *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 $	FY 09 $
Department of Social Services	GF - Cost	See Below	See Below
Office of Health Care Advocate	IF - Cost	220,000	226,000

Municipal Impact: None

Explanation

This bill makes numerous changes to the Department of Social Services' (DSS) HUSKY managed care programs.

Sections 1 through 3 of the bill make managed care contracts subject to Freedom of Information policies. This change is not expected to have a direct fiscal impact on the state.

Section 4 allows the Office of the Attorney General (OAG) to review and inspect certain contracts between DSS and a managed care organization to provide certain services. The OAG could accommodate this provision without requiring additional resources.

Section 5 requires DSS to report additional information to the Medicaid Managed Care Council. These changes are not expected to have a direct fiscal impact on the state.

Section 6 requires DSS to conduct an annual secret shopper survey with respect to HUSKY MCO's application and enrollment processes as well as the availability of health providers. DSS must report the result of this survey to the General Assembly annually. The cost will be dependent upon the design and scope of this survey, and is estimated to be between $25,000 and $50,000 annually.

Section 7 of the bill would result in a cost for additional staff resources for the Office of the Healthcare Advocate (OHA) to assist HUSKY clients with information. Detail on these resources appears below:

Item	FY 08	FY 09
Senior Case Manager Salary	70,000	72,100
Junior Case Manager Salary	55,000	56,650
Fringe Benefits	75,250	77,508
Other Expenses	20,000	20,000
Total	**220,250**	**226,258**

These additional case managers would be required to carry out provisions in Section 7 of the bill since the number of HUSKY cases referred to OHA is anticipated to be significant. Also, performing HUSKY outreach would be a new job function for OHA.

It should be noted that the budget bill, sHB 7077, as favorably reported by the Appropriations Committee includes one Junior Case Manager and one clerical/technical position to assist in handling the general OHA caseload. In FY 06, OHA opened 2,200 cases and anticipates a caseload of approximately 4,000 by the end of FY 07.

Section 8 and 9 require DSS to establish a primary care case management (PCCM) system for HUSKY clients on a regional basis. HUSKY beneficiaries would have the choice to enroll in the PCCM system or the existing MCO system. The bill requires DSS to reimburse providers in this pilot for any medical and health care coordination services. The bill specifies that the PCCM not utilize a capitated payment system. DSS must contract with an administrative service organization (ASO) to coordinate the PCCM.

Under the current managed care system, DSS provides a capitated payment to the MCO's for each HUSKY client. The MCO's bear the risk for any costs which exceed their capitated payment.

The bill does not require the PCCM ASO to bear any risk for the cost of services provided to the HUSKY clients, nor to provide any

utilization review. The ASO further has no incentive to negotiate rates paid to hospitals or other providers. Therefore, it is likely that the per-person cost under a PCCM model will exceed that under the current capitated model. The extent of this increase is not known. It is also not known how many HUSKY beneficiaries would choose the PCCM system over the MCO system. For purposes of illustration, a 5% increase in costs for a 10,000 person program would require an additional $1.3 million annually.

The bill does not specify what entity is to be responsible for meeting federal and state reporting requirements under the PCCM system. It is not clear whether federal reimbursement can be received for services provided without such reporting.

The bill includes additional public input, review and reporting requirements for DSS concerning the PCCM that will result in increased administrative costs to the department.

sHB 7077 contains $2.5 million in each year of the biennium to implement a HUSKY PCCM system in Windham and Waterbury.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 7322

AN ACT CONCERNING MEDICAID MANAGED CARE REFORM.

SUMMARY:

This bill makes a number of changes in how the Department of Social Services (DSS) delivers, and is accountable for, health care services the law requires it to provide to HUSKY A and B beneficiaries. Specifically, it:

1. makes the performance of HUSKY managed care contracts a governmental function under the Freedom of Information Act (FOIA), regardless of the value of the contract;

2. subjects HUSKY and other Medicaid contracts between DSS and managed care organizations (MCO) to the attorney general's review;

3. requires the DSS commissioner to include additional MCO accounting information in the department's reports to the Medicaid managed Care Council;

4. requires DSS to develop and implement a voluntary primary care case management program for HUSKY recipients; and

5. requires MCOs to transfer to DSS any drug or other rebates they receive.

Finally, it requires the Office of the Health Care Advocate to provide informational assistance to HUSKY A and B recipients.

EFFECTIVE DATE: July 1, 2007, except for the FOIA provisions, which are effective upon passage.

MEDICAID MANAGED CARE MCOs DISCLOSURE OF RECORDS

DSS Contracts and FOIA

The bill requires that certain language be included in contracts, and documents related to the contracts, between DSS and managed care organizations serving individuals receiving HUSKY A or B or other Medicaid benefits. The bill specifies that the contracts and documents include contracts and agreements with providers and subcontractors, documents concerning rates paid to them, and documents concerning operational standards. The requirement applies to contracts of any value.

The bill includes MCOs providing services to HUSKY and other Medicaid beneficiaries in the definition of a governmental function. Thus the contracts must (1) entitle DSS to copies of records and files related to the contract's performance and (2) indicate that the records and files are subject to disclosure under FOIA. Anyone denied access to the records or files must first file a complaint with the Freedom of Information Commission.

ATTORNEY GENERAL'S REVIEW OF HUSKY CONTRACTS

The bill subjects to the attorney general's review and inspection all (1) contracts DSS maintains with HUSKY A and B MCOs, as well as any covering other Medicaid beneficiaries and (2) all documents maintained by MCOs that are related to performing the contracts. These include (1) contracts and agreements with providers and subcontractors, (2) documents concerning rates paid to the subcontractors and providers, and (3) documents concerning operational standards.

When conducting this review or inspection, the attorney general must ensure that the contract language benefits the HUSKY enrollees. The attorney general may, at the same time he does this review, advise the DSS commissioner, the governor, and the chairpersons of the Human Services and Appropriations committees of any concerns he has with the contracts.

Only HUSKY A and B enrollees use MCOs at this time. Other Medicaid recipients receive their services on a fee-for-service basis.

REPORTS ON MCO CONTRACTS

The bill requires DSS, by January 1, 2008, to include in its monthly report to the Medicaid Managed Care Council the total dollar value of each MCO contract, along with an accounting of money allocated for and actually spent on:

1. preventive, primary, specialty, and dental care;
2. care and case management services;
3. outreach and advertising;
4. administrative costs;
5. profit margins;
6. subcontractors; and
7. any other non-medical expenses.

Also by that date, and annually thereafter, the commissioner must provide (presumably to the council) the following for each MCO contracting with it:

1. any pharmaceutical rebates that pharmaceutical manufacturers provide to the MCO,
2. salaries and fringe benefits for the 10 highest-paid MCO employees responsible for HUSKY administration,
3. the total dollar value of any pools that will be withheld from providers if the cost of services rendered is higher than expected, and
4. any other rebate a manufacturer, vendor, or health care product and equipment vendor or distributor provides to the MCO or

one of its subsidiaries.

SECRET SHOPPER SURVEY

The bill requires DSS, on an annual basis, to conduct a secret shopper survey of any MCO it contracts with. The survey must gauge the MCO's application and enrollment processes' effectiveness and assess the availability of "health care provider services" for new and existing enrollees. DSS must use a consistent methodology when conducting the survey to permit a fair comparison of results from one year to the next. Beginning January 1, 2008, the commissioner must annually report on the surveys' results to the Human Services and Appropriations committees.

PRIMARY CARE CASE MANAGEMENT

By January 1, 2008, DSS must begin implementing a voluntary primary care case management (PCCM) program on no less than a regional basis for HUSKY A and B enrollees. Once implemented, HUSKY enrollees must be given a choice of receiving services through PCCM or managed care (presumably MCO-based care). (Presumably, only enrollees in regions that have PCCM would have this choice.)

The bill defines PCCM as a system of care in which health care services are coordinated by a primary care provider (PCP) assigned to, or chosen by, the program enrollee. PCCM does not include a capitation payment system. The bill requires DSS to ensure that PCCM enrollees have access to dental and behavioral health services, which must be part of the PCCM system.

Currently, HUSKY A and B is a capitated health care system in which DSS pays a fixed monthly rate to MCOs for each HUSKY recipient enrolled in that MCO. The MCO is expected to provide all the HUSKY-covered health services the enrollee is entitled to receive.

Under the bill, participating PCPs must be reimbursed for any medical services and health care coordination they provide to PCCM enrollees. The PCPs must provide the enrollees' primary care services and arrange for specialty care as needed. The network of PCPs DSS

uses must include health care professionals employed at community health centers and school-based health clinics.

The bill requires DSS to contract with an administrative services organization (ASO) to coordinate the availability of services under PCCM. And it permits the department to contract directly with any medical provider or group of providers to facilitate PCCM implementation. When selecting the entity to administer PCCM (which, presumably is the ASO), DSS may not select any MCO, or any subsidiary of, affiliate of, or related company in the control of "the" MCO currently under contract with DSS to serve the HUSKY population. (DSS currently contracts with four MCOs.)

The bill requires the DSS commissioner to develop a program to involve the public in the PCCM system's design and implementation and to ensure ongoing public involvement. The program must include the opportunity to submit written comments and broad distribution of information and opportunities to the public and to consumers, consumer advocacy groups, medical providers, and other organizations involved in health care. The information must include one or more preliminary documents identifying the options DSS is considering for implementing PCCM. All informational materials must be available to people with disabilities and to those who do not speak English.

The PCCM system must include training and educational activities for (1) participating providers, (2) outreach personnel who promote the program, and (3) HUSKY beneficiaries who opt to enroll in PCCM.

Any PCCM enrollee must be given the option of asking DSS to change his or her PCP. DSS determines these requests on a case-by-case basis.

The bill requires DSS to provide monthly reports on its progress in planning and developing the PCCM system to the Medicaid Managed Care Council. And annually, beginning no later than six months after PCCM is implemented, DSS must conduct a comprehensive review of

the program that includes costs, beneficiary and provider satisfaction surveys, access and utilization reports, administrative efficiency reports, and recommendations for improvements. Once the review is complete, DSS must submit a report of its results to the council.

The bill permits the DSS commissioner to seek a waiver of federal Medicaid or State Children's Health Insurance Program law to implement PCCM. And the commissioner may implement policies and procedures to implement the program while in the process of adopting regulations, provided she publishes notice of intent in the Connecticut Law Journal within 20 days after implementation. The policies remain valid until final regulations are adopted.

Finally, the bill allows the HUSKY servicer (the administrative service organization that acts as the enrollment broker) to enroll HUSKY beneficiaries in PCCM, as well as managed care plans.

HUSKY MCOS TO TRANSFER REBATES TO DSS

The bill requires HUSKY MCOs or their subsidiaries to transfer to DSS any rebate they receive from pharmaceutical companies or health care product and equipment manufacturers, vendors, or distributors. (Presumably, this would not apply to the MCOs' commercial business but only to HUSKY business.) DSS must apply these amounts to its HUSKY budget for the fiscal year.

HEALTH CARE ADVOCATE TO PROVIDE INFORMATION

The bill requires the Office of the Health Care Advocate to provide informational assistance to HUSKY A and B recipients. It must include, at a minimum, information on:

1. selecting the HUSKY Plan option that best meets the enrollee's needs (presumably this is help with choosing an MCO or PCCM),
2. the enrollment process;
3. primary care provider selection;

4. assistance in negotiating the managed care and Medicaid systems to access health care services;

5. assistance with billing issues (in general, billing would only occur under HUSKY B for those families required to pay premiums or co-payments); and

6. collaboration with state agency personnel to resolve eligibility, enrollment, and access issues.

BACKGROUND

FOIA, Governmental Function, HUSKY Managed Care, and Caselaw

By law, whenever a state agency has a contract with a person to perform a governmental function and the contract is worth more than $2.5 million, the contract must (1) provide that the public agency is entitled to receive a copy of records and files related to the performance of the governmental function and (2) indicate that these records and files are subject to the FOIA and the agency can disclose them.

"Governmental function" is defined as the administration or management of a public agency's program, which program has been authorized by law to be administered or managed by a person where (1) the person receives funding from the public agency to do so; (2) the agency is involved in or regulates to a significant extent these activities, regardless of the degree; and (3) the person participates in formulating governmental policies or decisions in connection with the program's administration or management.

Over the last few years, academic researchers, health advocates, and others have tried to get information from DSS on the four MCOs currently serving the HUSKY A and B population, such as the number of specialists and the fees the MCOs pay for services rendered. In many instances, the information has been refused because the MCOs believe it is proprietary. DSS has generally accepted that position. Those seeking the information have attempted to get the information

through an FOIA request, which the FOI commission has granted.

But the MCOs (except for WellCare) appealed to the Superior Court, which dismissed the appeals, as a group, in November 2006, in part concluding that the MCOs, for all intents and purpose, are performing a government function and therefore subject to the FOIA (*Health Net of Connecticut, et. al,* v. *Freedom of Information Commission*, Nos. CV 060401028S, CV 064010429S, CV 064010430S,, CV 064009521S; November 29, 2006). The case is on appeal to the Supreme Court and is currently awaiting further articulation from the Superior Court judge.

Related Bill

sSB 1425 (Files 357 and 692) contains provisions related to the FOIA and MCOs, as well as provisions concerning PCCM.

Legislative History

The House referred the bill (File 380) to the Government Administration and Elections Committee, which gave it a favorable report. The House referred the bill to the Appropriations Committee, which favorably reported the substitute.

The substitute

1. removes the provision calling for PCCM to be statewide in 2013,
2. eliminates the increase in the rates MCOs must pay providers,
3. removes the pay-for-performance provisions, and
4. removes the requirement that DSS hire a medical director to make medical necessity determinations.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 19 Nay 0 (03/22/2007)

Government Administration and Elections Committee

Joint Favorable
Yea 10 Nay 0 (04/18/2007)

Appropriations Committee

Joint Favorable Substitute
Yea 31 Nay 11 (04/30/2007)